MEDICAL ASSISTANCE ACT

26-18-1. Short title.
This chapter shall be known and may be cited as the "Medical Assistance Act."

26-18-2. Definitions.
As used in this chapter:
(1) "Applicant" means any person who requests assistance under the medical programs of the state.
(2) "Client" means a person who the department has determined to be eligible for assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.
(3) "Division" means the Division of Health Care Financing within the department, established under Section 26-18-2.1.
(4) "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act.
(5) "Medical or hospital assistance" means services furnished or payments made to or on behalf of recipients of medical or hospital assistance under state medical programs.
(6) (a) "Passenger vehicle" means a self-propelled, two-axle vehicle intended primarily for operation on highways and used by an applicant or recipient to meet basic transportation needs and has a fair market value below 40% of the applicable amount of the federal luxury passenger automobile tax established in 26 U.S.C. Sec. 4001 and adjusted annually for inflation.
(b) "Passenger vehicle" does not include:
(i) a commercial vehicle, as defined in Section 41-1a-102;
(ii) an off-highway vehicle, as defined in Section 41-1a-102; or
(iii) a motor home, as defined in Section 13-14-102.
(7) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

26-18-2.1. Division -- Creation.
There is created, within the department, the Division of Health Care Financing which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Utah Medical Assistance Program established in Section 26-18-10, in accordance with the provisions of this chapter and applicable federal law.

26-18-2.2. Director -- Appointment -- Responsibilities.
The director of the division shall be appointed by the executive director of the department. The director of the division may employ other employees as necessary to implement the provisions of this chapter, and shall:
(1) administer the responsibilities of the division as set forth in this chapter;
(2) prepare and administer the division's budget; and
(3) establish and maintain a state plan for the Medicaid program in compliance with federal law and regulations.

26-18-2.3. Division responsibilities -- Emphasis -- Periodic assessment.
(1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall:
(a) establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay;
(b) deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity or appropriateness; and
(c) place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.
(2) The division shall implement and utilize cost-containment methods, where possible, which may include, but are not limited to:
(a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;
(b) preadmission certification of nonemergency admissions;
(c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;
(d) second surgical opinions;
(e) procedures for encouraging the use of outpatient services;
(f) consistent with Sections 28-18-2.4 and 58-17a-605.1, a Medicaid drug program;
(g) coordination of benefits; and
(h) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.
(3) The director of the division shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.

26-18-2.4. Medicaid drug program.
(1) A Medicaid drug program developed by the department under Subsection 26-18-2.3 (2)(f):
(a) shall, notwithstanding Subsection 26-18-2.3(1)(b), be based on clinical and cost-related factors which include medical necessity as determined by a provider in accordance with administrative rules established by the Drug Utilization Review

Board; and

(b) may include therapeutic categories of drugs that may be exempted from the drug program.

(2) (a) (i) The department shall study the Medicaid drug program for fiscal year 2003-04, but may not implement the program unless the department reports its findings and recommendations, including any proposed rules to the Legislative Executive Appropriations Committee and Legislative Management Committee at their August 2003 meeting, or if a meeting is not held in August, at the September 2003 meeting, for their review and recommendations.

(ii) The Legislative Executive Appropriations Committee and Legislative Management Committee shall review the Medicaid drug program proposed by the department and may:

(A) recommend that the department implement the drug program;

(B) recommend that the department modify the drug program;

(C) recommend that the department terminate the drug program; or

(D) recommend to the governor that he call a special session of the Legislature to review and approve the drug program.

(b) The department may use the Medicaid drug program developed and approved under Subsection (2)(a) in subsequent fiscal years.

(3) The department shall report its findings and recommendations regarding the Medicaid drug program to the Legislative Health and Human Services Interim Committee by August 30, 2003, and to the Legislative Health and Human Services Appropriations Subcommittee during the 2004 General Session.

26-18-3. Administration of Medicaid program by department -- Disciplinary measures and sanctions -- Funds collected.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) (a) The department shall implement the Medicaid program through administrative rules in conformity with this chapter, Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the requirements of Title XIX, and applicable federal regulations.

(b) (i) The rules adopted under Subsection (2)(a) shall include, in addition to other rules necessary to implement the program, the standards used by the department for determining eligibility for Medicaid services, the services and benefits to be covered by the Medicaid program, and reimbursement methodologies for providers under the Medicaid program.

(ii) If the department implements a change in the Medicaid State Plan, initiates a new Medicaid waiver, submits an amendment to an existing Medicaid waiver, or initiates a rate change requiring public notice under state or federal law, the department shall, prior to adopting the change, report to either the Legislative Executive Appropriations Committee or the Legislative Health and Human Services Appropriations Subcommittee and include in the report:

(A) the proposed change in services or reimbursement;

(B) the effect of an increase or decrease in services or benefits on individuals and families;

(C) the degree to which any proposed cut may result in cost-shifting to more expensive services in health or human service programs; and

(D) the effect of any proposed increase of benefits or reimbursement on current and future appropriations from the Legislature to the department.

(iii) Any rules adopted by the department under this Subsection (2) are subject to review and reauthorization by the Legislature in accordance with Section 63-46a-11.5.

(3) The department may, in its discretion, contract with the Department of Human Services or other qualified agencies for services in connection with the administration of the Medicaid program, including but not limited to the determination of the eligibility of individuals for the program, recovery of overpayments, and enforcement of fraud and abuse laws, consistent with Section 26-20-13, to the extent permitted by law and quality control services.

(4) The department shall provide, by rule, disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively may not extend beyond:

(a) termination from the program;

(b) recovery of claim reimbursements incorrectly paid; and

(c) those specified in Section 1919 of Title XIX of the federal Social Security Act.

(5) Funds collected as a result of a sanction imposed

under Section 1919 of Title XIX of the federal Social Security Act shall be deposited in the General Fund as nonlapsing dedicated credits to be used by the division in accordance with the requirements of that section.

(6) (a) In determining whether an applicant or recipient is eligible for a service or benefit under this part or Chapter 40, Utah Children's Health Insurance Act, the department shall, if Subsection (6)(b) is satisfied, exclude from consideration one passenger vehicle designated by the applicant or recipient.

(b) Before Subsection (6)(a) may be applied:

(i) the federal government must:

(A) determine that Subsection (6)(a) may be implemented within the state's existing public assistance-related waivers as of January 1, 1999;

(B) extend a waiver to the state permitting the implementation of Subsection (6)(a); or

(C) determine that the state's waivers that permit dual eligibility determinations for cash assistance and Medicaid are no longer valid; and

(ii) the department must determine that Subsection (6)(a) can be implemented within existing funding.

(7) (a) For purposes of this Subsection (7):

(i) "aged, blind, or disabled" shall be defined by administrative rule; and

(ii) "spend down" means an amount of income in excess of the allowable income standard that must be paid in cash to the department or incurred through the medical services not paid by Medicaid.

(b) In determining whether an applicant or recipient who is aged, blind, or disabled is eligible for a service or benefit under this chapter, the department shall use 100% of the federal poverty level as:

(i) the allowable income standard for eligibility for services or benefits; and

(ii) the allowable income standard for eligibility as a result of spend down.

26-18-3.1. Medicaid expansion.

(1) The purpose of this section is to expand the coverage of the Medicaid program to persons who are in categories traditionally not served by that program.

(2) Within appropriations from the Legislature, the department may amend the state plan for medical assistance to provide for eligibility for Medicaid:

(a) on or after July 1, 1994, for children 12 to 17 years old who live in households below the federal poverty income guideline; and

(b) on or after July 1, 1995, for persons who have incomes below the federal poverty income guideline and who are aged, blind, or disabled.

(3) (a) Within appropriations from the Legislature, on or after July 1, 1996, the Medicaid program may provide for eligibility for persons who have incomes below the federal poverty income guideline.

(b) In order to meet the provisions of this subsection, the department may seek approval for a demonstration project under 42 U.S.C. Section 1315 from the secretary of the United States Department of Health and Human Services. This demonstration project may also provide for the voluntary participation of private firms that:

(i) are newly established or marginally profitable;

(ii) do not provide health insurance to their employees;

(iii) employ predominantly low wage workers; and

(iv) are unable to obtain adequate and affordable health care insurance in the private market.

(4) Services available for persons described in this section shall include required Medicaid services and may include one or more optional Medicaid services if those services are funded by the Legislature. The department may also require persons described in this section to meet an asset test.

26-18-3.5. Copayments by health service recipients, spouses, and parents.

(1) The department shall selectively provide for enrollment fees, premiums, deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and parents, within the limitations of federal law and regulation.

(2) (a) The department shall seek approval under the department's Section 1115 Medicaid waiver to cap enrollment fees for the Primary Care Network Demonstration Project in accordance with Subsection (2)(b).

(b) Pursuant to a waiver obtained under Subsection (2)(a), the department shall cap enrollment fees for the primary care network at $15 per year for those persons who, after July 1, 2003, are eligible to begin receiving General Assistance under Section 35A-3-401.

26-18-3.6. Income and resources from institutionalized spouses.

(1) As used in this section:

(a) "Community spouse" means the spouse of an institutionalized spouse.

(b) (i) "Community spouse monthly income allowance" means an amount by which the minimum monthly maintenance needs allowance for the spouse exceeds the amount of monthly income otherwise available to the community spouse, determined without regard to the

allowance, except as provided in Subsection (1)(b)(ii).

(ii) If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse may not be less than the amount of the monthly income so ordered.

(c) "Community spouse resource allowance" is an amount by which the greatest of the following exceeds the amount of the resources otherwise available to the community spouse:

(i) $15,804;

(ii) the lesser of the spousal share computed under Subsection (4) or $76,740;

(iii) the amount established in a hearing held under Subsection (11); or

(iv) the amount transferred by court order under Subsection (11)(c).

(d) "Excess shelter allowance" for a community spouse means the amount by which the sum of the spouse's expense for rent or mortgage payment, taxes, and insurance, and in the case of condominium or cooperative, required maintenance charge, for the community spouse's principal residence and the spouse's actual expenses for electricity, natural gas, and water utilities or, at the discretion of the department, the federal food stamp standard utility allowance, exceeds 30% of the amount described in Subsection (9).

(e) "Family member" means a minor dependent child, dependent parents, or dependent sibling of the institutionalized spouse or community spouse who are residing with the community spouse.

(f) (i) "Institutionalized spouse" means a person who is residing in a nursing facility and is married to a spouse who is not in a nursing facility.

(ii) An "institutionalized spouse" does not include a person who is not likely to reside in a nursing facility for at least 30 consecutive days.

(g) "Nursing care facility" is defined in Section 26-21-2.

(2) The division shall comply with this section when determining eligibility for medical assistance for an institutionalized spouse.

(3) For services furnished during a calendar year beginning on or after January 1, 1999, the dollar amounts specified in Subsections (1)(c)(i), (1)(c)(ii), and (10)(b) shall be increased by the division by the amount as determined annually by the federal Health Care Financing Administration.

(4) The division shall compute, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse:

(a) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest; and

(b) a spousal share, which is 1/2 of the resources described in Subsection (4)(a).

(5) At the request of an institutionalized spouse or a community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the division shall promptly assess and document the total value described in Subsection (4)(a) and shall provide a copy of that assessment and documentation to each spouse and shall retain a copy of the assessment. When the division provides a copy of the assessment, it shall include a notice stating that the spouse may request a hearing under Subsection (11).

(6) When determining eligibility for medical assistance under this chapter:

(a) Except as provided in Subsection (6)(b), all the resources held by either the institutionalized spouse, community spouse, or both, are considered to be available to the institutionalized spouse.

(b) Resources are considered to be available to the institutionalized spouse only to the extent that the amount of those resources exceeds the amounts specified in Subsections (1)(c)(i) through (iv) at the time of application for medical assistance under this chapter.

(7) The division may not find an institutionalized spouse to be ineligible for medical assistance by reason of resources determined under Subsection (5) to be available for the cost of care when:

(a) the institutionalized spouse has assigned to the state any rights to support from the community spouse;

(b) (i) except as provided in Subsection (7)(b)(ii), the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment;

(ii) Subsection (7)(b)(i) does not prevent the division from seeking a court order seeking an assignment of support; or

(c) the division determines that denial of medical assistance would cause an undue burden.

(8) During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is eligible for medical assistance, the resources of the community spouse may not be considered to be available to the institutionalized spouse.

(9) When an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly for the cost of care in the nursing care facility, the division shall deduct from the spouse's monthly income the following amounts in the following order:

(a) a personal needs allowance, the amount of which is determined by the division;

(b) a community spouse monthly income allowance, but only to the extent that the

income of the institutionalized spouse is made available to, or for the benefit of, the community spouse;

(c) a family allowance for each family member, equal to at least 1/3 of the amount that the amount described in Subsection (10)(a)(i) exceeds the amount of monthly income of that family member; and

(d) amounts for incurred expenses for the medical or remedial care for the institutionalized spouse.

(10) (a) Except as provided in Subsection (10)(b), the division shall establish a minimum monthly maintenance needs allowance for each community spouse which is not less than the sum of:

(i) 150% of the current poverty guideline for a two-person family unit that applies to this state as established by the United States Department of Health and Human Services; and

(ii) an excess shelter allowance.

(b) The amount provided in Subsection (10)(a) may not exceed $1,976, unless a court order establishes a higher amount.

(11) (a) An institutionalized spouse or a community spouse may request a hearing with respect to the determinations described in Subsections (11)(e)(i) through (v) if an application for medical assistance has been made on behalf of the institutionalized spouse.

(b) A hearing under this subsection regarding the community spouse resource allowance shall be held by the division within 90 days from the date of the request for the hearing.

(c) If either spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance provided under Subsection (10), an amount adequate to provide additional income as is necessary.

(d) If either spouse establishes that the community spouse resource allowance, in relation to the amount of income generated by the allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance, an amount adequate to provide a minimum monthly maintenance needs allowance.

(e) A hearing may be held under this subsection if either the institutionalized spouse or community spouse is dissatisfied with a determination of:

(i) the community spouse monthly income allowance;

(ii) the amount of monthly income otherwise available to the community spouse;

(iii) the computation of the spousal share of resources under Subsection (4);

(iv) the attribution of resources under Subsection (6); or

(v) the determination of the community spouse resource allocation.

(12) (a) An institutionalized spouse may transfer an amount equal to the community spouse resource allowance, but only to the extent the resources of the institutionalized spouse are transferred to or for the sole benefit of the community spouse.

(b) The transfer under Subsection (12)(a) shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account the time necessary to obtain a court order under Subsection (12)(c).

(c) Title 26, Chapter 19, Medical Benefits Recovery Act, does not apply if a court has entered an order against an institutionalized spouse for the support of the community spouse.

26-18-3.7. Prepaid health care delivery systems.

(1) (a) Before July 1, 1996, the division may submit to the Health Care Financing Administration within the United States Department of Health and Human Services, an amendment to the state's freedom of choice waiver. That amendment shall provide that the following persons who are eligible for services under the state plan for medical assistance, who reside in Salt Lake, Utah, Davis, or Weber counties, shall enroll in the recipient's choice of a health care delivery system that meets the requirements of Subsection (2):

(i) by July 1, 1994, 40% of eligible persons;

(ii) by July 1, 1995, 65% of eligible persons; and

(iii) by July 1, 1996, 100% of eligible persons.

(b) The division may not enter into any agreements with mental health providers that establish a prepaid capitated delivery system for mental health services that were not in existence prior to July 1, 1993, until the application of the Utah Medicaid Hospital Provider Temporary Assessment Act with regard to a specialty hospital as defined in Section 26-21-2 that may be engaged exclusively in rendering psychiatric or other mental health treatment is repealed.

(c) The following are exempt from the requirements of Subsection (1)(a):

(i) persons who:

(A) receive medical assistance for the first time after July 1, 1996;

(B) have a mental illness, as that term is defined in

Section 62A-15-602; and

(C) are receiving treatment for that mental illness. The division, when appropriate, shall enroll these persons in a health care delivery system that meets the requirements of this section;

(ii) persons who are institutionalized in a facility designated by the division as a nursing facility or an intermediate care facility for the mentally retarded; or

(iii) persons with a health condition that requires specialized medical treatment that is not available from a health care delivery system that meets the requirements of this section.

(2) In submitting the amendment to the state's freedom of choice waiver under Subsection (1), the division shall ensure that the proposed health care delivery systems have at least the following characteristics, so that the system:

(a) is financially at risk, for a specified continuum of health care services, for a defined population, and has incentives to balance the patient's need for care against the need for cost control;

(b) follows utilization and quality controls developed by the department;

(c) is encouraged to promote the health of patients through primary and preventive care;

(d) coordinates care to avoid unnecessary duplication and services;

(e) conserves health care resources; and

(f) if permissible under the waiver, utilizes private insurance plans including health maintenance organizations and other private health care delivery organizations.

(3) Subsection (2) does not prevent the division from contracting with other health care delivery organizations if the division determines that it is advantageous to do so.

(4) Health care delivery systems that meet the requirements of this section may provide all services otherwise available under the state plan for medical assistance, except prescribed drugs.

(5) The division shall periodically report to the Health and Human Services Interim Committee regarding the development and implementation of the amendment to the state's freedom of choice waiver required under this section.

26-18-4. Department standards for eligibility under Medicaid -- Funds for abortions.

(1) The department may develop standards and administer policies relating to eligibility under the Medicaid program as long as they are consistent with Subsection 26-18-3(6). An applicant receiving Medicaid assistance may be limited to particular types of care or services or to payment of part or all costs of care determined to be medically necessary.

(2) The department shall not provide any funds for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is to perform an abortion, unless the life of the mother would be endangered if an abortion were not performed.

(3) Any employee of the department who authorizes payment for an abortion contrary to the provisions of this section is guilty of a class B misdemeanor and subject to forfeiture of office.

(4) Any person or organization that, under the guise of other medical treatment, provides an abortion under auspices of the Medicaid program is guilty of a third degree felony and subject to forfeiture of license to practice medicine or authority to provide medical services and treatment.

26-18-5. Contracts for provision of medical services -- Federal provisions modifying department rules -- Compliance with Social Security Act.

(1) The department may contract with other public or private agencies to purchase or provide medical services in connection with the programs of the division. Where these programs are used by other state agencies, contracts shall provide that other state agencies transfer the state matching funds to the department in amounts sufficient to satisfy needs of the specified program.

(2) All contracts for the provision or purchase of medical services shall be established on the basis of the state's fiscal year and shall remain uniform during the fiscal year insofar as possible. Contract terms shall include provisions for maintenance, administration, and service costs.

(3) If a federal legislative or executive provision requires modifications or revisions in an eligibility factor established under this chapter as a condition for participation in medical assistance, the department may modify or change its rules as necessary to qualify for participation; providing, the provisions of this section shall not apply to department rules governing abortion.

(4) The department shall comply with all pertinent requirements of the Social Security Act and all orders, rules, and regulations adopted thereunder when required as a condition of participation in benefits under the Social Security Act.

26-18-6. Federal aid -- Authority of executive director.

The executive director, with the approval of the governor, may bind the state to any executive or legislative provisions promulgated or enacted by the federal government which invite the state to participate in the distribution, disbursement or administration of any fund or service advanced, offered or contributed in whole or in part by the federal government for purposes consistent with the powers and duties of the department. Such funds shall be used as provided in this chapter and be administered by the department for purposes related to medical assistance programs.

26-18-7. Medical vendor rates.

Medical vendor payments made to providers of services for and in behalf of recipient households shall be based upon predetermined rates from standards developed by the division

in cooperation with providers of services for each type of service purchased by the division. As far as possible, the rates paid for services shall be established in advance of the fiscal year for which funds are to be requested.

26-18-8. Enforcement of public assistance statutes.

(1) The department shall enforce or contract for the enforcement of Sections 35A-1-503, 35A-3-108, 35A-3-110, 35A-3-111, 35A-3-112, and 35A-3-603 insofar as these sections pertain to benefits conferred or administered by the division under this chapter.

(2) The department may contract for services covered in Section 35A-3-111 insofar as that section pertains to benefits conferred or administered by the division under this chapter.

26-18-9. Prohibited acts of state or local employees of Medicaid program -- Violation a misdemeanor.

Each state or local employee responsible for the expenditure of funds under the state Medicaid program, each individual who formerly was such an officer or employee, and each partner of such an officer or employee is prohibited for a period of one year after termination of such responsibility from committing any act, the commission of which by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by Section 207 or Section 208 of Title 18, United States Code. Violation of this section is a class A misdemeanor.

26-18-10. Utah Medical Assistance Program -- Policies and standards.

(1) The division shall develop a medical assistance program, which shall be known as the Utah Medical Assistance Program, for low income persons who are not eligible under the state plan for Medicaid under Title XIX of the Social Security Act or Medicare under Title XVIII of that act.

(2) Persons in the custody of prisons, jails, halfway houses, and other nonmedical government institutions are not eligible for services provided under this section.

(3) The department shall develop standards and administer policies relating to eligibility requirements, consistent with Subsection 26-18-3(6), for participation in the program, and for payment of medical claims for eligible persons.

(4) The program shall be a payor of last resort. Before assistance is rendered the division shall investigate the availability of the resources of the spouse, father, mother, and adult children of the person making application.

(5) The department shall determine what medically necessary care or services are covered under the program, including duration of care, and method of payment, which may be partial or in full.

(6) The department shall not provide public assistance for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is for the performance of an abortion, unless the life of the mother would be endangered if an abortion were not performed.

(7) The department may establish rules to carry out the provisions of this section.

26-18-11. Rural hospitals.

(1) For purposes of this section "rural hospital" means a hospital located outside of a standard metropolitan statistical area, as designated by the United States Bureau of the Census.

(2) For purposes of the Medicaid program and the Utah Medical Assistance Program, the Division of Health Care Financing shall not discriminate among rural hospitals on the basis of size.

26-18-101. Definitions.

As used in this part:

(1) "Appropriate and medically necessary" means, regarding drug prescribing, dispensing, and patient usage, that it is in conformity with the criteria and standards developed in accordance with this part.

(2) "Board" means the Drug Utilization Review Board created in Section 26-18-102.

(3) "Compendia" means resources widely accepted by the medical profession in the efficacious use of drugs, including "American Hospital Formulary Services Drug Information," "U.S. Pharmacopeia - Drug Information," "A.M.A. Drug Evaluations," peer-reviewed medical literature, and information provided by manufacturers of drug products.

(4) "Counseling" means the activities conducted by a pharmacist to inform Medicaid recipients about the proper use of drugs, as required by the board under this part.

(5) "Criteria" means those predetermined and explicitly accepted elements used to measure drug use on an ongoing basis in order to determine if the use is appropriate, medically necessary, and not likely to result in adverse medical outcomes.

(6) "Drug-disease contraindications" means that the therapeutic effect of a drug is adversely altered by the presence of another disease condition.

(7) "Drug-interactions" means that two or more drugs taken by a recipient lead to clinically significant toxicity that is characteristic of one or any of the drugs present, or that leads to interference with the effectiveness of one or any of the drugs.

(8) "Drug Utilization Review" or "DUR" means the program designed to measure and assess, on a retrospective and prospective basis, the proper use of outpatient drugs in the Medicaid program.

(9) "Intervention" means a form of communication utilized by the board with a prescriber or pharmacist to inform about or influence prescribing or dispensing practices.

(10) "Overutilization" or "underutilization" means the use of a drug in such quantities that the desired therapeutic goal is not achieved.

(11) "Pharmacist" means a person licensed in this state to engage in the practice of pharmacy under Title 58, Chapter 17a, Pharmacy Practice Act.

(12) "Physician" means a person licensed in this state to practice medicine and surgery under Section 58-67-301, Utah Medical Practice Act, or osteopathic medicine under Section 58-68-301, Utah Osteopathic Medical Practice Act.

(13) "Prospective DUR" means that part of the drug utilization review program that occurs before a drug is dispensed, and that is designed to screen for potential drug therapy problems based on explicit and

predetermined criteria and standards.

(14) "Retrospective DUR" means that part of the drug utilization review program that assesses or measures drug use based on an historical review of drug use data against predetermined and explicit criteria and standards, on an ongoing basis with professional input.

(15) "Standards" means the acceptable range of deviation from the criteria that reflects local medical practice and that is tested on the Medicaid recipient database.

(16) "SURS" means the Surveillance Utilization Review System of the Medicaid program.

(17) "Therapeutic appropriateness" means drug prescribing and dispensing based on rational drug therapy that is consistent with criteria and standards.

(18) "Therapeutic duplication" means prescribing and dispensing the same drug or two or more drugs from the same therapeutic class where periods of drug administration overlap and where that practice is not medically indicated.

26-18-102. DUR Board -- Creation and membership -- Expenses.

(1) There is created a 12-member Drug Utilization Review Board responsible for implementation of a retrospective and prospective DUR program.

(2) (a) Except as required by Subsection (b), as terms of current board members expire, the executive director shall appoint each new member or reappointed member to a four-year term.

(b) Notwithstanding the requirements of Subsection (a), the executive director shall, at the time of appointment or reappointment, adjust the length of terms to ensure that the terms of board members are staggered so that approximately half of the board is appointed every two years.

(c) Persons appointed to the board may be reappointed upon completion of their terms, but may not serve more than two consecutive terms.

(d) The executive director shall provide for geographic balance in representation on the board.

(3) When a vacancy occurs in the membership for any reason, the replacement shall be appointed for the unexpired term.

(4) The membership shall be comprised of the following:

(a) four physicians who are actively engaged in the practice of medicine or osteopathic medicine in this state, to be selected from a list of nominees provided by the Utah Medical Association;

(b) one physician in this state who is actively engaged in academic medicine;

(c) three pharmacists who are actively practicing in retail pharmacy in this state, to be selected from a list of nominees provided by the Utah Pharmaceutical Association;

(d) one pharmacist who is actively engaged in academic pharmacy;

(e) one person who shall represent consumers;

(f) one person who shall represent pharmaceutical manufacturers, to be recommended by the Pharmaceutical Manufacturers Association; and

(g) one dentist licensed to practice in this state under Title 58, Chapter 7, Dentists and Dental Hygienists Act, who is actively engaged in the practice of dentistry, nominated by the Utah Dental Association.

(5) Physician and pharmacist members of the board shall have expertise in clinically appropriate prescribing and dispensing of outpatient drugs.

(6) The board shall elect a chair from among its members who shall serve a one-year term, and may serve consecutive terms.

(7) (a) Members shall receive no compensation or benefits for their services, but may receive per diem and expenses incurred in the performance of the member's official duties at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(b) Members may decline to receive per diem and expenses for their service.

(c) (i) Higher education members who do not receive salary, per diem, or expenses from the entity that they represent for their service may receive per diem and expenses incurred in the performance of their official duties from the committee at the rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.

(ii) Higher education members may decline to receive per diem and expenses for their service.

26-18-103. DUR Board -- Responsibilities.

The board shall:

(1) develop rules necessary to carry out its responsibilities as defined in this part;

(2) oversee the implementation of a Medicaid retrospective and prospective DUR program in accordance with this part, including responsibility for approving provisions of contractual agreements between the Medicaid program and any other entity that will process and review Medicaid drug claims and profiles for the DUR program in accordance with this part;

(3) develop and apply predetermined criteria and standards to be used in retrospective and prospective DUR, ensuring that the criteria and standards are based on the compendia, and that they are developed with professional input, in a consensus fashion, with provisions for timely revision and assessment as necessary. The DUR standards developed by the board shall reflect the local practices of physicians in order to monitor:

(a) therapeutic appropriateness;

(b) overutilization or underutilization;

(c) therapeutic duplication;

(d) drug-disease contraindications;

(e) drug-drug interactions;

(f) incorrect drug dosage or duration of drug treatment; and

(g) clinical abuse and misuse;

(4) develop, select, apply, and assess interventions and remedial strategies for physicians, pharmacists, and recipients that are educational and not punitive in nature, in order to improve the quality of care;

(5) disseminate information to physicians and pharmacists to ensure that they are aware of the board's duties and powers;

(6) provide written, oral, or electronic reminders of patient-specific or drug-specific information, designed to ensure recipient, physician, and pharmacist confidentiality, and suggest changes in prescribing or dispensing practices designed to improve the quality of care;

(7) utilize face-to-face discussions between experts in drug therapy and the prescriber or pharmacist who has been targeted for educational intervention;

(8) conduct intensified reviews or monitoring of selected prescribers or pharmacists;

(9) create an educational program using data provided through DUR to provide active and ongoing educational outreach programs to improve prescribing and dispensing practices, either directly or by contract with other governmental or private entities;

(10) provide a timely evaluation of intervention to determine if those interventions have improved the quality of care;

(11) publish an annual report, subject to public comment prior to its issuance, and submit that report to the United States Department of Health and Human Services by December 1 of each year. That report shall also be submitted to legislative leadership, the executive director, the president of the Utah Pharmaceutical Association, and the president of the Utah Medical Association by December 1 of each year. The report shall include:

(a) an overview of the activities of the board and the DUR program;

(b) a description of interventions used and their effectiveness, specifying whether the intervention was a result of underutilization or overutilization of drugs, without disclosing the identities of individual physicians, pharmacists, or recipients;

(c) the costs of administering the DUR program;

(d) any fiscal savings resulting from the DUR program;

(e) an overview of the fiscal impact of the DUR program to other areas of the Medicaid program such as hospitalization or long-term care costs;

(f) a quantifiable assessment of whether DUR has improved the recipient's quality of care;

(g) a review of the total number of prescriptions, by drug therapeutic class;

(h) an assessment of the impact of educational programs or interventions on prescribing or dispensing practices; and

(i) recommendations for DUR program improvement;

(12) develop a working agreement with related boards or agencies, including the State Board of Pharmacy, Physicians' Licensing Board, and SURS staff within the division, in order to clarify areas of responsibility for each, where those areas may overlap;

(13) establish a grievance process for physicians and pharmacists under this part, in accordance with Title 63, Chapter 46b, Administrative Procedures Act;

(14) publish and disseminate educational information to physicians and pharmacists concerning the board and the DUR program, including information regarding:

(a) identification and reduction of the frequency of patterns of fraud, abuse, gross overuse, inappropriate, or medically unnecessary care among physicians, pharmacists, and recipients;

(b) potential or actual severe or adverse reactions to drugs;

(c) therapeutic appropriateness;

(d) overutilization or underutilization;

(e) appropriate use of generics;

(f) therapeutic duplication;

(g) drug-disease contraindications;

(h) drug-drug interactions;

(i) incorrect drug dosage and duration of drug treatment;

(j) drug allergy interactions; and

(k) clinical abuse and misuse;

(15) develop and publish, with the input of the State Board of Pharmacy, guidelines and standards to be used by pharmacists in counseling Medicaid recipients in accordance with this part. The guidelines shall ensure that the recipient may refuse counseling and that the refusal is to be documented by the pharmacist. Items to be discussed as part of that counseling include:

(a) the name and description of the medication;

(b) administration, form, and duration of therapy;

(c) special directions and precautions for use;

(d) common severe side effects or interactions, and therapeutic interactions, and how to avoid those occurrences;

(e) techniques for self-monitoring drug therapy;

(f) proper storage;

(g) prescription refill information; and

(h) action to be taken in the event of a missed dose; and

(16) establish procedures in cooperation with the State Board of Pharmacy for pharmacists to record information to be collected under this part. The recorded information shall include:

(a) the name, address, age, and gender of the recipient;

(b) individual history of the recipient where significant, including disease state, known allergies and drug reactions, and a comprehensive list of medications and relevant devices;

(c) the pharmacist's comments on the individual's drug therapy;

(d) name of prescriber; and

(e) name of drug, dose, duration of therapy, and directions for use.

26-18-104. Confidentiality of records.

(1) Information obtained under this part shall be treated as confidential or controlled information under Title 63, Chapter 2, Government Records Access and Management Act.

(2) The board shall establish procedures insuring that the information described in Subsection 26-18-103(16) is held confidential by the pharmacist, being provided to the physician only upon request.

(3) The board shall adopt and implement procedures designed to ensure the confidentiality of all information collected, stored, retrieved, assessed, or analyzed by the board, staff to the board, or contractors to the DUR program, that identifies individual physicians, pharmacists, or recipients. The board may have access to identifying information for purposes of carrying out intervention activities, but that identifying information may not be released to anyone other than a member of the board. The board may release cumulative nonidentifying information for research purposes.

26-18-105. Drug prior approval program.

Any drug prior approval program approved or implemented by the board shall meet the following conditions:

(1) no drug may be placed on prior approval for other than medical reasons;

(2) the board shall hold a public hearing at least 90 days prior to placing a drug on prior approval;

(3) the board shall provide evidence that placing a drug class on prior approval will not impede quality of recipient care and that the drug class is subject to clinical abuse or misuse;

(4) no later than nine months after any drug class is placed on prior approval, it shall be reconsidered;

(5) the program shall provide either telephone or fax approval or denial at least Monday through Friday, within 24 hours after receipt of the prior approval request;

(6) the program shall provide for the dispensing of at least a 72-hour supply of the drug in an emergency situation or on weekends;

(7) the program may not be applied to prevent acceptable medical use for appropriate off-label indications; and

(8) any drug class placed on prior approval shall receive a majority vote by the board for that placement, after meeting the requirements described in Subsections (1) through (7).

26-18-106. Advisory committees.

The board may establish advisory committees to assist it in carrying out its duties under this part.

26-18-107. Retrospective and prospective DUR.

(1) The board, in cooperation with the division, shall include in its state plan the creation and implementation of a retrospective and prospective DUR program for Medicaid outpatient drugs to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

(2) The retrospective and prospective DUR program shall be operated under guidelines established by the board under Subsections (3) and (4).

(3) The retrospective DUR program shall be based on guidelines established by the board, using the mechanized drug claims processing and information retrieval system to analyze claims data in order to:

(a) identify patterns of fraud, abuse, gross overuse, and inappropriate or medically unnecessary care; and

(b) assess data on drug use against explicit predetermined standards that are based on the compendia and other sources for the purpose of monitoring:

(i) therapeutic appropriateness;

(ii) overutilization or underutilization;

(iii) therapeutic duplication;

(iv) drug-disease contraindications;

(v) drug-drug interactions;

(vi) incorrect drug dosage or duration of drug treatment; and

(vii) clinical abuse and misuse.

(4) The prospective DUR program shall be based on guidelines established by the board and shall provide that, before a prescription is filled or delivered, a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from:

(a) therapeutic duplication;

(b) drug-drug interactions;

(c) incorrect dosage or duration of treatment;

(d) drug-allergy interactions; and

(e) clinical abuse or misuse.

(5) In conducting the prospective DUR, a pharmacist may not alter the prescribed outpatient drug therapy without the consent of the prescribing physician. This section does not effect the ability of a pharmacist to substitute a generic equivalent.

26-18-108. Penalties.

Any person who violates the confidentiality provisions of this part is guilty of a class B misdemeanor.

26-18-109. Immunity.

There is no liability on the part of, and no cause of action of any nature arises against any member of the board, its agents, or employees for any action or omission by them in effecting the provisions of this part.

26-18-301. Definitions.

As used in this part:

(1) "Medically underserved population" means the population of an urban or rural area or a population group designated by the department as having a shortage of primary health care services.

(2) "Primary health care" means:

(a) basic and general health care services given when a person seeks assistance to screen for or to prevent illness and disease, or for simple and common illnesses and injuries; and

(b) care given for the management of chronic diseases.

(3) "Primary health care services" include, but are not limited to:

(a) services of physicians, all nurses, physician's assistants, and dentists licensed to practice in this state under Title 58;

(b) diagnostic and radiologic services;

(c) preventive health services including, but not limited to, perinatal services, well-child services, and other services that seek to prevent disease or its consequences;

(d) emergency medical services;

(e) preventive dental services; and

(f) pharmaceutical services.

26-18-302. Department to award grants -- Applications.

(1) Within appropriations specified by the Legislature for this purpose, the department may make grants to public and nonprofit entities for the cost of operation of providing primary health care services to medically underserved populations.

(2) Grants by the department shall be awarded based on applications submitted to the department in the manner and form prescribed by the department and by Section 26-18-303. The application shall contain a requested award amount, budget, and narrative plan of the manner in which the applicant intends to provide the primary care services described in this chapter.

(3) Applicants under this chapter must demonstrate to the department that they will operate in a manner such that no person shall be denied service by reason of his inability to pay. This does not preclude the applicant from seeking payment from the patient, a third party, or government agency that is authorized or that is under legal obligation to pay such charges.

26-18-303. Content of applications.

Applications for grants under this chapter shall include:

(1) a statement of specific, measurable objectives, and the methods to be used to assess the achievement of those objectives;

(2) the precise boundaries of the area to be served by the entity making the application, including a description of the medically underserved population to be served by the grant;

(3) the results of an assessment of need demonstrating that the population to be served has a need for the services provided by the applicant;

(4) a description of the personnel responsible for carrying out the activities of the grant along with a statement justifying the use of any grant funds for the personnel;

(5) letters and other forms of evidence showing that efforts have been made to secure financial and professional assistance and support for the services to be provided under the grant;

(6) a list of services to be provided by the applicant;

(7) the schedule of fees to be charged by the applicant;

(8) the estimated number of medically underserved persons to be served with the grant award; and

(9) other provisions as determined by the department.

26-18-304. Process and criteria for awarding grants.

The department shall establish rules in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act, governing the application form, process, and criteria it will use in awarding grants under this chapter. In awarding grants, the department shall consider the extent to which the applicant:

(1) demonstrates that the area or a population group to be served under the application has a shortage of primary health care and that the services will be located so that they will provide assistance to the greatest number of persons residing in such area or included in such population group;

(2) utilizes other sources of funding, including private funding, to provide primary health care;

(3) demonstrates the ability and expertise to serve traditionally medically underserved populations including persons of limited English-speaking ability, single heads of households, the elderly, persons with low incomes, and persons with chronic diseases;

(4) demonstrates that it will assume financial risk for a specified number of medically underserved persons within its catchment area for a predetermined level of care on a prepaid capitation basis; and

(5) meets other criteria determined by the department.

26-18-305. Report on implementation.

The department shall report to the Health and Human Services Interim Committee by November 1, 1994, and every year thereafter on the implementation of the grant program for primary care services. The report shall include a description of the scope and level of coverage provided to low-income persons by primary care grant programs and by the medical assistance program established in Section 26-18-10. The report shall also include recommendations to minimize the loss of revenue by hospitals that serve a disproportionate share of persons under Section 26-18-10.

26-18-401. Medicaid waiver.

(1) (a) Before July 1, 1995, the division shall submit to the Secretary of the United States Department of Health and Human Services an application for a Medicaid Waiver under 42 U.S.C. Section 1315. The purpose of the waiver is to expand the coverage of the Medicaid program, and to the extent permissible under the waiver, private health insurance plans to low income, otherwise uninsured persons who are in eligibility categories not traditionally served by the Medicaid program.

(b) Prior to submitting the application under Subsection (1)(a), the department shall submit to the Health and Human Services Interim Committee a summary of the application and proposal for implementing the waiver.

(c) Prior to adopting any rules or policies to implement the waiver, the department shall submit to the Health and Human Services Interim Committee the proposed rules and policies.

(2) Implementation and execution of this waiver by the department will be within appropriations from the Legislature.

(3) The department shall establish by rule the policies governing eligibility, income limitations, cost sharing, participating in private insurance plans, benefit plan, and voluntary employee enrollment by employers who volunteer to participate.

(4) The department shall provide an annual report to the Health and Human Services Interim Committee on the progress and results of the waiver implementation.

26-18-402. Medicaid Restricted Account.

(1) There is created a restricted account in the General Fund known as the Medicaid Restricted Account.

(2) (a) Any general funds appropriated to the department for the state plan for medical assistance or for the Division of Health Care Financing that are not expended by the department in the fiscal year for which the

general funds were appropriated and which are not otherwise designated as nonlapsing shall lapse into the Medicaid Restricted Account.

(b) The account shall earn interest and all interest earned shall be deposited into the account.

(c) The Legislature may appropriate monies in the restricted account to fund programs that expand medical assistance coverage and private health insurance plans to low income persons who have not traditionally been served by Medicaid, including the Utah Children's Health Insurance Program created in Chapter 40.